



O C U L A R
S E R V I C E S
M A N A G E M E N T

Dear Parents,

The Lakewood City Schools are partnering with Ocular Services Management to offer comprehensive eye health and vision examinations at all of the elementary schools. Please complete the following information and the Student Medical History form if you would like your child to participate in this program.

Student Name _____ Birth Date _____ Sex _____ Grade _____
Parent or Guardian _____ Phone _____
Address _____
Email _____ School _____

Insurance Information

Medical Insurance Name _____ ID# _____
Vision Insurance Name _____ ID# _____
Subscribers Name _____ DOB _____ SS# _____

Kindly check all boxes:

- I authorize Ocular Services Management to perform a comprehensive eye health and vision examination on my child. I understand that my insurance will be billed and that I will be responsible for any amount not covered by my insurance company.

- If my child needs glasses I authorize Ocular Services Management to select a frame with my child. In the event that my insurance does not cover glasses I will be contacted by Ocular Services Management and payment is required before the order will be placed.

- I authorize Ocular Services Management to share a copy of my child's vision examination report with appropriate school official(s).

Signature _____ Relationship to child _____





Student Name: _____ Date _____
 Completed By: _____ Relationship to student _____
 Eye Surgery/Conditions _____
 Medications: _____
 Allergies _____

<i>Check the column which best represents the occurrence of each symptom.</i>	<i>Never 0</i>	<i>Seldom 1</i>	<i>Occasionally 2</i>	<i>Frequently 3</i>	<i>Always 4</i>
Blur when looking at near					
Double vision					
Headaches with near work					
Words run together reading					
Burning, itchy, watery eyes					
Falls asleep reading					
Sees worse at end of day					
Skips / repeats lines when reading					
Dizziness / nausea with near work					
Head tilt / closing one eye when reading					
Difficulty copying from chalkboard					
Avoids near work / reading					
Omits small words when reading					
Writes uphill / downhill					
Misaligns digits / columns of numbers					
Reading comprehension down					
Poor / inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says "I can't" before trying					
Avoids sports / games					
Poor hand / eye (poor handwriting)					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his / her time well					
Does not make change well					
Loses belongings / things					
Car / motion sickness					
Forgetful / poor memory					